EMS & Trauma Section
EMS for Children,
PO Box 202951,
1400 Broadway,
Room C314A,
Helena MT 59620

EMSC/CHILD READY CONNECTION *NEWSLETTER*

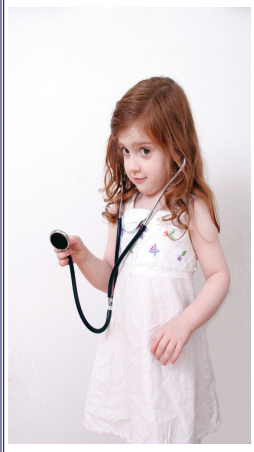
SEPTEMBER VOLUME 2, ISSUE 9

A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation)* is provided to children and adolescents, no matter where they live, attend school or travel.



Child Ready Montana– State Partnership of Regionalized Care (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

THE *RIGHT* CARE AT THE *RIGHT* PLACE AT THE *RIGHT* TIME WITH THE *RIGHT* RESOURCES!

Exciting news and events are going on this month! TRIVIA- ANSWER AND WIN

Death of a Child in the ED including written protocols –see page 6-7

Real patient videos for training– see page 9

Check out the FREE EMERGENCY *PEDIATRIC CARE COURSE*– SPONSORED BY THE MT EMSC= OCTOBER 2, 2014 in BILLINGS– Get more details-PAGE 9

WHAT'S NEW?	PAGE

MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services

CHILD READY montana

EMS Montana Emergency Care

September begins on the same day of the week as December every year, because there are 91 days separating September and December, which is a multiple of seven (the number of days in the week). No other month ends on the same day of the week as September in any year.

SEPTEMBER IS NATIONAL CHILDHOOD OBESITY AWARENESS MONTH.
Montana's NICHQ's fact sheet: HTTP://WWW.NICHQ.ORG/

MONTANA STATE FACT SHEET

KEY POINTS

- Montana ranks 4th in overall prevalence with 25.6% of children considered either overweight or obese.
- The Montana prevalence of overweight and obese children has fallen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 28.4 % of low-income children age 2-5 are overweight or obese in Montana.

This year's observance marks the 30-year celebration of the EMS for Children (EMSC) Program. For the last three decades, the EMSC Program has successfully raised awareness among healthcare professionals, EMS and trauma system planners, and the general public that children respond differently – physically, emotionally, and psychologically – to illness or injury than do adults.

Happy 30th EMS-C!!

National Association of State EMS Officials

THE NATIONAL ASSOCIATION OF STATE EMS OFFICIALS- THE PROFESSIONAL ASSOCIATION FOR STATE EMERGENCY MEDICAL SERVICES OFFICIALS

Vision- A seamless nationwide network of coordinated and accountable state, regional and local EMS and emergency care systems. The systems use public health principles, data and evidence as a basis for safe and effective care in day-to-day operations as well as during catastrophic events**.**

Mission-NASEMSO supports its members in developing EMS policy and oversight, as well as in providing vision, leadership and resources in the development and improvement of state, regional and local EMS and emergency care systems.

Strategy– They achieve their mission by the participation of all the states and territories, by being a strong national voice for EMS, an acknowledged key resource for EMS information and policy, and a leader in developing and disseminating evidence-based decisions and policy.

NAEMSO Goals:

- To promote the orderly development of coordinated EMS systems across the nation.
- To promote uniformly high quality care of acutely ill and injured patients.
- To provide a forum for the exchange of information and the discussion of common concerns among state EMS officials.
- To facilitate interstate cooperation in such areas as patient transfer, communications and reciprocity of EMS personnel.
- To disseminate pertinent information to our membership and others.
- **To maintain ongoing and effective liaison with state and national governments, professional organizations, and other appropriate public and private entities.**
- To improve the quality and efficiency of state EMS program administration.
- To enhance the professional knowledge, skill and abilities of state EMS officials and staff.
- To encourage research and evaluation in all areas of EMS.
- To serve as a permanent national advocacy group for EMS.

https://www.nasemso.org/

DID YOU KNOW?

Jim DeTienne, Supervisor of the Montana Department of Public Health and Human Services, Emergency Medical Services and Trauma Systems is the President of NAEMSO?

Jim was recently a presenter at the National EMS for Children Program Meeting in Arlington, Virginia. He was a member of a distinguished panel speaking on the Growth and Development of the EMS for Children Program. He spoke on the systems approach to Pediatric Care, Education standards, data and performance improvement, safe transport for children in ground ambulances, pediatric disaster preparedness and injury prevention. (We are lucky to have a Montana voice at the National level!!)

Other members of the panel included representatives from the American College of Emergency Physicians (ACEP); the National Emergency Nurses Association (ENA); the National Academy of Pediatrics (AAP); the National Association of EMT (NAEMT) and the Federal office of Health and Human Services.

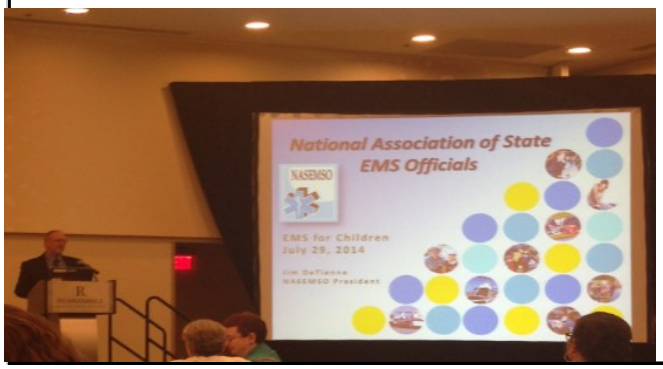
The National American Academy of Pediatrics representative spoke on how EMSC infrastructure in states serve as important voices for children and an ally for AAP chapters that can and should be leveraged to better meet the needs of children.

The National Association of EMT (NAEMT) spoke on the commitment to raise the awareness of pediatric care in EMS; the support of the design, purchase and use of pediatric equipment on EMS ambulances; the support of training in Pediatric Care in EMS; and the development of the Emergency Pediatric Care Curriculum.

The National Emergency Nurses Association (ENA) supports standardized approaches to pediatric care with the Emergency Nurses Pediatric Course (ENPC.) As well as promoting Pediatric Readiness for hospitals and in EMS Prehospital settings

The Federal Office of Health and Human Services referred to the **Emergency *Care for Children – Growing Pains: Recommendations–*** promoting the enhancement of the emergency care workforce with pediatric knowledge and skills; Pediatric emergency coordinators in EDs; Improve pediatric patient safety with evidence-based approaches to reducing errors; Foster family-centered care; Enhance pediatric priorities in disaster preparedness; and Support evidence-base programs for pediatric emergency care.

We truly thank all the National Organizations and the Montana Chapters for supporting the Montana Emergency Medical Services for Children Program and helping to make Montana Pediatric Ready throughout the continuum of care.



CHILD READY MONTANA

Child Ready Montana is a State Partnership Regionalization of Care Grant (SPROC) funded by the Federal Health Resource and Services Administration (HRSA). Montana is one of 6 states to be awarded this grant with the Montana Emergency Medical Services for Children (EMSC) Program.

Child Ready Montana will be continuing Mock Codes in the Eastern Region this fall. Along with Mock Codes Cultural Sensitivity presentation will be competed at each site. Child Ready MT will be working with each site looking at equipment, transfer protocols, and training needs to facilitate child readiness in rural critical access facilities.

Updates to the Mock Codes will be codes run specifically for EMS and Providers along with scavenger hunts for nurses. Regionalizing care for children in Montana is the main focus for Child Ready. We will be working with larger hospitals to recognize resources available. Please stay posted for upcoming dates for site visits.

Please feel free to contact Kassie Runsabove to schedule cultural sensitivity trainings. Kassie.runsabove@sclhs.net or call 406-238-6216.

Upcoming events: MEMSA conference Pediatric Mock Code Simulation October 3rd, 2014 (Billings)

Come learn more about the Child Ready MT Project and participate in pediatric Mock code trainings.

PSYCHOLOGICAL FIRST AID (PFA), is an intervention model to help people of all ages deal with trauma-related stress. It does not assume that anyone that suffers something traumatic will develop mental health problems. There are many different reactions that people have after an emergency. Sometimes these reactions can lead to distress that can get in the way of proper coping.

PFA's goals are to establish a human connection in a compassionate way, enhance safety, calm over-whelmed survivors, allow survivors to express their needs, connect survivors to support networks, provide recovery information, empower survivors and support to help people recover from their reactions. People can become trained on PFA face-to-face or online through a six-hour interactive training. There is also a PFA mobile app that can assist responders.

PFA online includes a 6-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally-narrated course is for individuals new to disaster response who want to learn the core goals of PFA, as well as for seasoned practitioners who want a review.

PFA features innovative activities, video demonstrations, and mentor tips from the nation's trauma experts and survivors. PFA online also offers a Learning Community where participants can share about experiences using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training.

This project was funded by SAMHSA, NCPTSD, NACCHO, and HHS Office of the Surgeon General, and the Office of the Civilian Volunteer Medical Reserve Corps.

This course has 6 CE credits available through the National Association of Social Workers, American Psychological Association**,** American Psychological Association, California Board of Behavioral Sciences, and the **Board of Registered Nursing.** See more at: http://learn.nctsn.org/enrol/index.php?

OBSERVATIONAL STUDY OF FAMILY MEMBER PRESENCE FOR PEDIATRIC EMERGENCY DEPARTMENT PROCEDURES

A study published in *Pediatric Emergency Care* aimed to observe the proportion of family members who choose to remain present during children's pediatric emergency department (ED) procedures in actual clinical situations.

Family members were observed while children had invasive procedures in a pediatric ED. Data were collected on whether family members chose to remain present or leave during the procedure, and family member and health care worker behaviors. Consent to participate in the study was obtained after the observation, and family members were surveyed regarding demographics, anxiety, and previous experiences.

Fifty-nine children undergoing 66 procedures and accompanied by 83 family members were enrolled. The median age of the children was 69 months. The family members consisted of 64% mothers and 24% fathers, with a median age of 33 years. The most common procedures were vascular access (25), laceration repair (11), and urethral catheterization (9).

Overall, 73% of the family members stayed during the child's procedure, 18% left, and 9% showed some mixture of staying and leaving. Health care workers asked the family members to leave twice, encouraged them to leave once, and used nonverbal cues to exclude the family members twice. Caregivers helped to restrain the child 35% of the time.

This study concludes that family members remain present during actual children's ED procedures less often than they indicate they would in hypothetical scenario surveys.

DEATH OF A CHILD IN THE EMERGENCY DEPARTMENT

The American College of Emergency Physicians and the American Academy of Pediatrics collaborated to produce a recent technical report published in *Pediatrics*.

This technical report describes the background information, consensus opinion, and evidence, where available, to support the recommendations of the policy statement on the principles of care after the death of a child in the emergency medicine (ED).

Nearly 20% of the 40,000 children younger than 14 years who die each year occur in an outpatient location, such as the ED. **Moreover, the death of child in the ED is unique in that it is often sudden, unexpected, and occurs without a previously established physician-patient care relationship.**

ED physicians must be prepared to provide emotional and cultural support, as well as deal with procedural and legal issues that arise with the death of a child despite limited experience, exposure, and training.

Key factors that should be considered or have an impact after the death of a child in the ED include:

- **the importance of education of health professionals regarding palliative, end-of-life, and bereavement care to children and families;**
- **family-centered care; team-oriented approach;**
- **notification of pediatrician and subspecialists;**
- **the decision/discussion of postmortem examinations and organ tissue donation; and**
- **assisting ED staff, out-of-hospital providers, and others experiencing critical incident stress.**

THE MONTANA PEDIATRIC READINESS ASSESSMENT REPORT INDICATED THAT 36 OUT OF 52 RESPONDING MONTANA HOSPITALS DID NOT HAVE A CHILD DEATH POLICY.

The AAP, ACEP, and ENA support the following principles:

- Use a patient-centered, family-focused, and team-oriented approach when a child dies in the ED.

- Provide personal, compassionate, and individualized support to families while respecting social, spiritual, & cultural diversity.

- Provide effective, timely, attentive, and sensitive palliative care to patients with life span–limiting conditions and anticipated death presenting to the ED for end-of-life care.

- Clarify with the family the child's medical home and promptly notify the child's primary care provider

ED procedures provide a coordinated response to a child's death including the following WRITTEN protocols:

- family member presence during and after attempted resuscitation; including preterm delivery resuscitation;

- end-of-life care/anticipated death in the ED of a child with a life span–limiting condition;

- collaboration with law enforcement staff to address forensic concerns while providing compassionate care; identification and reporting of cases of suspected child maltreatment;

- institutional position on permitting the practice of procedures involving the newly deceased and best practice–outlining procedures after the death of a child (e.g., a "death packet" with guidelines for completion of a death certificate, organ donation, etc.);

- Identification of resources, including other individuals and organizations, that can respond to the ED to assist staff and bereaved families, such as child life specialist, chaplaincy, social work, behavioral health, hospice, or palliative care staff;

- Identification and notification of medical examiner/coroner regarding all deaths, as directed by applicable law; routine offering of postmortem autopsy to families for all nonmedical examiner-coroner cases;

- Formal voluntary support and programs for ED staff and trainees, out-of-hospital providers, and others who are experiencing distress and self-care after difficult or troubling ED cases

- Support of child death review activities to understand causes of preventable child death; Medical-legal issues and best practice surrounding completion of death certificates;

- The ED health care team routinely considers care for the bereaved members of the patient's family that may include information and arrangements for bereavement care services, condolence cards, and follow-up with family to address any concerns or questions. **For more information see: http://pediatrics.aappublications.org**

OJJDP Releases Law Enforcement Guide on Recognizing Child Abuse

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) recently released the guide "***Recognizing When a Child's Injury or Illness Is Caused by Abuse***." The guide provides information to help differentiate between physical abuse and accidental injury during a child abuse investigation. The guide also identifies questions that law enforcement should address during an investigation, describes how to conduct a caretaker assessment when a child is injured, and highlights ways to work with the medical community to distinguish types of injuries and bruises.

For more information see: http://www.ojjdp.gov/enews/14juvjust/140728.html

BUMC PUBLISHES STUDY ON EMS IN ACTIVE SHOOTER SCENARIOS

Emergency Medical Service (EMS) responders felt better prepared to respond to an active shooter incident after receiving focused tactical training according to a new study by researchers at Boston University in the journal *Prehospital and Disaster Medicine*. This is the first study to specifically examine the EMS provider comfort level with respect to entering a scene where a shooter has not yet been neutralized or working with law enforcement personnel during that response. http://www.bumc.bu.edu/2014/07/11/emergency-responders-more-comfortable-in-active-shootings-scenarios-after-training/

RECALL HAS BEEN ISSUED FOR CHILDREN'S MEDICAL VENTURES, GEL-E DONUT & SQUISHON2.

Children's Medical Ventures received a number of complaints about visible mold on the outer surface of Gel-E Donut and Squishon 2 gel-filled products. The detected mold was determined to be *Cladosporium* and *Penicillium Fungi*, commonly found molds. *Cladosporium* has been known to cause several different types of invasive infections, including skin, eye, sinus, and brain infections especially in vulnerable populations such as neonates, critically ill patients, and patients with an impaired or weakened immune system. *Cladosporium* and *Penicillium Fungi* can also cause difficulty in breathing or allergic reaction. The use of affected product may cause serious adverse health consequences, including death.

FREE ONLINE EMERGENCY RESPONDER HEALTH MONITORING AND SURVEILLANCE TRAINING

An **Emergency Responder Health Monitoring and Surveillance (**ERHMS) system is a critical component in protecting emergency workers from the safety and health risks inherent in emergency response work. An ERHMS system includes specific recommendations and tools for all phases of a response, including the pre-deployment, deployment, and post-deployment phase. Medical monitoring and surveillance can help identify worker exposures and symptoms early in the course of an emergency response that in turn can prevent or reduce adverse physical and psychological outcomes.

The National Institute for Occupational Safety and Health (NIOSH) and the U.S. National Response Team are offering a free ERHMS training course that provides the necessary tools for implementing health monitoring and surveillance of emergency response workers. Important procedures for pre-deployment, deployment, and post-deployment are outlined. The intended audience includes local, regional, state, tribal, and federal personnel who are responsible for the occupational safety and health of responders.

For more information http://blogs.cdc.gov/niosh-science-blog/2014/07/29/erhms-training

TRIVIA CONTEST:

First 3 to answer the questions wins a free all expense paid trip to Hawaii ……not really— but how about a Pediatric Crash Card ($25 value)? —Email rsuzor@mt.gov)

1. How old is the EMS for Children Program?
2. What free course is being offered on October 2! See below for the answer!

TRAINING RESOURCES:

Oregon EMSC and ReelDx Announce Partnership to Publish Medical Videos from 911 Responders

ReelDx, the leading provider of real-patient videos, has launched the first online library of real-pediatric patient video case studies designed to train emergency medical services (EMS) providers. Sponsored by Oregon EMSC, the new pediatric cases within the prehospital library provides EMS professionals with short videos of real patient encounters in the field and in emergency rooms, substantial case data and imagery, and peer-authored and reviewed write-ups of each case. Each case includes a video of about one minute in length along with patient medical history, dispatch information, and first responder interventions used. Many cases also include rich supplemental materials, such as still pictures of trauma scenes, caregiver interviews, EKG, and other test results.

See https://meded.reeldx.com/#/libraries/prehospital/cases or contact Philip Engle. The registration is free.

Oct. 2 *EMERGENCY PEDIATRIC CARE COURSE* (BILLINGS)

Preconference training for MEMSA at the Billings Convention Center. **Sponsored by EMSTS EMS for Children Program-This is a hybrid course with a portion to be completed online PRIOR to Oct 2.**

NAEMT's **Emergency Pediatric Care (EPC)** course focuses on the care of sick and injured children, addressing a full spectrum of emergency illnesses, injuries and scenarios that an EMS practitioner might encounter. The course provides an in-depth understanding of the pathophysiology of the most common pediatric emergency issues, and stresses critical thinking skills to help practitioners make the best decisions for their patients.

EPC uses the Pediatric Assessment Triangle (PAT) as a tool to help EMS practitioners rapidly and accurately assess pediatric patients and incorporates family centered care throughout all scenarios. Training encompasses lectures, hands-on skills practice and small group critical thinking discussions.

The 16 hour course is for emergency medical responders, EMTs, Paramedics, nurses, physician assistants and physicians. This course is offered at Basic or Combined levels. The provider course may be offered in one of two formats: the traditional onsite face-to-face format with lectures and skill stations; or a hybrid format, where a portion of the course is taken online in an interactive, web-based format, followed by a one day face-to-face for skill station instructions and evaluations.

Don't miss out! For further information contact Shari Graham at sgraham2@mt.gov or at (406) 444-6098. Deadline for registration is September 12, 2014.